

Which Messages on Patient Safety Should the Federal Government Promote?

HCFA Research with Medicare Beneficiaries

Elder Care Award Winning Paper

Patient Safety Initiative 2000:
Spotlighting Strategies, Sharing Solutions

Chicago Illinois, October 6, 2000

Christopher P. Koepke, Ph.D.
Social Science Research Analyst
Health Care Financing Administration
Mail Stop S1-15-03
7500 Security Blvd.
Baltimore, MD 21244

Ckoepke@hcfa.gov

410-786-5877

Elaine K. Swift, Ph.D.
Scholar-in-Residence
Institute of Medicine, National Academy of Sciences
Washington, DC

Jorge A. Ferrer, MD
Sr. Vice President, Health Informatics
Medical Internet Solutions
Bethesda, MD

David J. Miranda, Ph.D.
Social Science Research Analyst
Health Care Financing Administration
Baltimore, MD

This paper represents the opinions of the authors and does not necessarily represent the opinions of the Health Care Financing Administration or any of the other organizations with which the authors are affiliated.

Abstract

Can widespread popular interest in medical errors be transformed into an active public role in prevention? To address this challenge, the federal government is mounting a public health campaign that will promote tips on patient safety developed by the Agency on Healthcare Research and Quality (AHRQ). In this study, the Health Care Financing Administration (HCFA) examined how receptive Medicare beneficiaries were to these and other error-prevention messages. Its research suggests that messages should be consistent with a collaborative doctor-patient relationship paradigm and specify which actions patients should adopt and the ways patients should adopt them.

In the wake of the Institute of Medicine's landmark report on medical errors,¹ the federal government's Quality Interagency Coordination Task Force (QuIC) is mounting a consumer campaign to encourage patients to take a role in reducing medical errors. One of the first efforts has been the development of a brochure by the Agency for Healthcare Research and Quality (AHRQ), "20 Tips to Prevent Medical Errors" (available at www.ahrq.gov).

To decide which messages to most heavily promote, QuIC has drawn from research on Medicare beneficiaries conducted by the Health Care Financing Administration (HCFA). Medicare beneficiaries are among the heaviest users of the nation's health services, spending an average of \$7087 per year for health services, compared to \$1814 for the population as a whole (1996 per capita health care expenses from the Medicare Expenditure Panel Survey, 2000). The adoption of behaviors to prevent medical errors by this population of heavy health care users could positively influence the health care system as a whole.

Study Objectives and Methods

Objectives. This research addresses the following major objectives:

- 1) Identify the individual messages on error prevention that beneficiaries liked best in order to help federal agencies promote those most likely to be widely adopted.
- 2) Identify the kinds of patient-provider relationships that beneficiaries prefer. When formulating new messages or deciding between existing choices, it is important to base those messages on a model of patient-provider relations that consumers realistic, effective, or desirable for other reasons. Otherwise, consumers will be less likely to be receptive, no matter how valid the other content is.^{2,3,4}

Participants. Findings were based on the results from eight two-hour focus groups with Medicare beneficiaries. Each focus group contained nine participants. Participants were evenly divided among men and women and 38% were African American while 62% were White. Ages ranged from 65 to 80. The groups were held in two regions: four in Baltimore and four in Richmond. In both places, two of the groups were composed of Medicare beneficiaries with lower education (high school or less), and two with higher education (some college courses or more). In the six groups that performed the ranking exercise described below, the participants were moderate to high users of medical services.

Procedures. In all eight groups, moderators probed what the term "medical errors" meant to participants; their receptiveness to assertive and self-protective interactions with health providers; and the kinds of relationships they valued with health providers.

Additionally, in six of the groups, participants were asked to rank 28 messages (tips) about what patients can do to reduce medical errors. Twenty of the messages were drawn from AHRQ's "20 Tips" brochure. The additional eight were developed by HCFA staff or came from other organizations interested in reducing medical errors. Each of the 28 messages were placed into subject categories based on those formulated by AHRQ: five addressed hospital/surgery issues (e.g. make sure you and your doctors agree on what is to be done); nine dealt with prescriptions (e.g. tell your doctor about everything you are taking, including herbal supplements and vitamins); and 14 concerned a range of issues (e.g. be an active member of your health care team). Participants were asked to separately rank tips in the three categories in terms of how likely they were to act upon them. Each participant ranked the tips independently of the other participants. The tips are listed in table 1 based on how highly they were ranked in their respective categories.

After each category was ranked, the tips ranked the highest and lowest were discussed by the group as a whole. During these discussions, moderators asked the participants why they ranked certain tips high or low, what the tips meant to the participants, and how the participants would implement the action recommended by the tips. The varying composition of the 28 tips coupled with the discussions held after the rankings provided the evidence for the conclusions reached in the conclusion.

Focus Group Findings

Medical Errors and Their Contexts. Focus group participants were asked “what comes to mind when you hear the term medical errors.” Almost immediately, they began discussing surgical errors that they had heard in the media (e.g. people having the wrong leg amputated). Soon after, however, discussions turned to pharmaceutical and diagnostic issues. Respondents were clearly aware that medical errors could occur around medicines. Some offered personal experiences of what they viewed as pharmaceutical and diagnostic errors.

Highest and Lowest Ranked Messages. Each tip, the category within which it was ranked, and its rank within that category is listed in table 1.

[Table 1 about here]

Highest Ranked Messages. As Table 1 shows, messages that received the highest rankings tended to be those that indicated specific ways for patients to inform their health professionals, and to inform themselves about what their health professionals were doing. Subjects preferred directive messages that suggested what they should tell their doctors about, and what kinds of medical attention they should actively track. Even the high scoring tips from the general category

(e.g. "Learn about your condition and treatments by asking your doctor and nurse and by using other reliable sources.") were more specific than most of the others in the same group.

Keeping your doctor informed was also a positively ranked theme. As one subject said, "[Y]ou can die if you don't tell your doctor, so it's pretty important that you tell him." There was also a sense that these were actions they could accomplish, though many did not seem to be carrying them out. Some participants thought that their doctors solicited information about drugs and over-the-counter substances they were currently taking, making it unnecessary for them to raise the subject. Participants also relied heavily on the pharmacists use of drug registries to identify drug interactions.

The top-scoring hospital and general category tips had a related theme of informing yourself. Participants said they want to know what is wrong and how to get better, within limits. Many also said they wanted to know as much as they could about their conditions. This was true across education levels. As one person from a noncollege-educated group said, "Once a doctor diagnoses you for a certain thing, you want to learn as much as you can about it." However, not everyone thought they were qualified to evaluate what was reliable information. Moreover, not everyone wished to be well informed. As one person said, "It makes you worry."

According to participants, "making sure you and [your doctors] agree on what will be done" is "vital" to minimizing mistakes during surgery. Some confusion existed over how people would make sure that they and their doctors agreed. While many participants would ask or "talk with" their physicians, others trusted that doctors would make sure to communicate with one another. Although some did not feel qualified to intervene in the event of disagreement, that feeling was not universal. As one participant explained, "I'm a layman, so I want to make

sure that they both agree. If they don't agree, let's find out why you don't agree and what change do we have to make."

Lowest Ranked Messages. Some of the lower ranked messages were simply too general to be meaningful. For instance, the general tip "Know that 'more' is not always better" generated the comments "it didn't really mean anything" and "more of what? More treatment? More information?"

Some messages that were specific ranked low because they called on patients to directly challenge doctors and other health professionals. For example, one participant explained that he did not wish to ask health care workers to wash their hands because they "would feel a little bit insulted," and he "would be afraid" of recriminations. Participants considered other specific tips unnecessary because health care professionals had already acted to ensure that problems in these areas were highly unlikely to arise. For example, many believed pharmacists verified prescription information with doctors' offices.

Consumer Messages and Patient-Doctor Relationships. These focus groups suggest that Medicare beneficiaries with different educational levels are attracted to a paradigm that stresses collaborative patient-doctor relationships. Many talked about the importance of providing and soliciting medical information from professionals. To be sure, there are limits. Many questioned their ability to independently evaluate medical information, and most underscored how important it was, in the end, to trust the advice and beneficence of their physicians.

These focus group findings on the paradigm of patient-doctor relations preferred by Medicare beneficiaries at first appear to contradict the considerable amount of interaction

research that suggests that the elderly prefer a more paternalistic model in which the patient is highly passive, and leaves problem solving and decision making to doctors.^{5,6,7,8,9,10} To some extent, our findings could be the result of participant self-selection: the healthier and more articulate and efficacious may very well be those more likely to participate in focus groups. Our findings may also in part be the result of focus group dynamics causing participants to provide views that appear to be more "correct," which in this case would be support for collaborative patient-doctor relations.

However, the discrepancy between focus group findings and other research on patient-doctor relations may not be as contradictory as it first may seem. While the issue requires further investigation than was possible in this project, it appears that participants recognized that patient passivity is common--and quite understandable. However, it is not the sort of behavior that is admired; only after considerable prodding would any participants admit to having been passive themselves. Rather, the great majority of participants recognized the value of being more proactive, a finding consistent with other research that has demonstrated support for--if not consistent adherence to--proactivity.^{11,12,13,14,15}

Support for a paradigm of collaborative patient-doctor relations appeared to form a schema through which participants filtered the consumer messages on medical errors. Those that they highly ranked are consistent with the schema. None call for patients to challenge doctors. Rather, they call on patients to know about their conditions, to tell their doctors about relevant information, and to understand the information their doctors provide them. Those that they ranked low are predicated on a far more assertive, even controlling, model of patient participation inconsistent with the schema.

Conclusion

Focus groups of both college- and noncollege-educated beneficiaries were very familiar with the topic of medical errors and strongly endorsed the importance of acting to reduce errors.

Participants also supported the importance of being more proactive in their relationships with health professionals, a necessary belief if patients are to participate in the effort to reduce errors.

The ranking research tool used in this research was quite effective at reducing the number of potential messages to discuss during the group and in identifying common threads among high and low ranked messages. Our findings suggest that consumer messages on reducing medical errors would work best if they had the following characteristics:

- *Advocate a collaborative doctor-patient relationship.* Participants were more receptive to messages that called for patients to work with, rather than challenge, health professionals.
- *Specify action to be taken.* Participants preferred directive messages that they readily understood, e.g. "Make sure that your doctor knows about any allergies and adverse reactions you have had to medicines." They did not respond to sloganeering, e.g. "Know that 'more' is not always better."
- *Clearly indicate mode of implementation.* Even if patients are comfortable with the message and convinced of its importance, they need directions on how they should act on it. For example, many liked the message, "If you are having surgery, make sure that you, your doctor, and your surgeon are clear on exactly what will be done." However, not everyone understood how to achieve that agreement, specificity was not enough.

In the early stages of the public education campaign, “tips” concerning multiple contexts (e.g. pharmacy, hospital, and primary care) will be communicated together. That Medicare consumers prefer specific messages suggests a need to consider crafting the messages and channels for specific contexts. Perhaps tips specific to medicines need to be communicated together through channels that will reach consumers when they are faced with medicine issues (e.g. in doctor’s offices and at pharmacies).

Two areas of additional research are needed to improve inform this educational effort. First, is a need to move beyond this formative testing that identified useful themes to testing the efficacy of the effort itself. Further research tracking the impact of a medical errors prevention campaign would be highly beneficial to this end. Second, is a need to study the receptiveness of health care professionals to engaging in these types of patient collaborations to reduce medical errors.

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Table 1: Tips, the categories with which they were ranked and their rank within that category.		
	Tip Category	Rank in Category
Highest Ranked Tips		
Make sure all of your doctors know about everything you are taking. This includes prescription and over-the-counter medicines, and dietary supplements such as vitamins and herbs.	Medicines	1
Make sure your doctor knows about any allergies and adverse reactions you have had to medicines.	Medicines	2
Keep a record of the medicines you take and be sure to tell your doctor about them and any allergies you might have.	Medicines	3
If you are having surgery, make sure that you, your doctor, and your surgeon all agree and are clear on exactly what will be done.	Hospital/Surg.	1
Choose a hospital that has a lot of experience in treating your condition.	Hospital/Surg.	2
Learn about your condition and treatments by asking your doctor and nurse and by using other reliable sources.	General	1
Speak up if you have questions or concerns.	General	2
Make sure that all health professionals involved in your care have important health information about you.	General	3
Middle Ranked Tips		
If you have any questions about the directions on your medicine labels, ask.	Medicines	4
Ask for information about your medicines in terms you can understand – both when your medicines are prescribed and when you receive them.	Medicines	5
When you are being discharged from the hospital, ask your doctor to explain the treatment plan you will use at home.	Hospital	3
If you have a choice, choose a hospital at which many patients have the procedure or surgery you need.	Hospital	4
Write your questions before you see the doctor; check for answers before you leave.	General	4
Make sure that someone, such as your personal doctor, is in charge of your care.	General	5
Take a written list of your symptoms to your doctors appointment.	General	6

Before you say yes, ask if you have treatment options.	General	7
Ask your specialist to talk or write to your personal doctor.	General	8
If you don't like the treatment, ask for the alternatives.	General	9
Lowest Ranked Tips		
Ask for written information about the side effects your medicine could cause.	Medicines	6
When you pick up your medicine from the pharmacy, ask: Is this the medicine that my doctor prescribed.	Medicines	7
Ask your pharmacist for the best device to measure your liquid medicine. Also, ask questions if you're not sure how to use it.	Medicines	8
When your doctor writes you a prescription, make sure you can read it.	Medicines	9
If you are in a hospital, consider asking all health care workers who have direct contact with you whether they have washed their hands.	Hospital/Surg	5
Be an active member of your health care team.	General	10
If you have a test, don't assume that no news is good news.	General	11
What you don't know about your health care can kill you.	General	12
Ask a family member or friend to be there with you and to be your advocate.	General	13
Know that "more" is not always better.	General	14